

MATERNITY RECORD SUMMARY

Instruction Manual

NOVEMBER 1979

INTERNATIONAL FERTILITY RESEARCH PROGRAM
RESEARCH TRIANGLE PARK NC 27709 USA

MAT MAN 101 -- dcx189

PH-MA-657

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I. INTRODUCTION

Purpose

The purpose of this record is to collect, analyze and report data relating to obstetric delivery. These data may be of use to clinicians, program administrators, health planners and research investigators. This manual has been prepared to ensure the uniform reporting of data by all Contributors engaged in cooperative research with the International Fertility Research Program (IFRP). It is suggested that the Contributor read this manual carefully before beginning the study and refer to it when questions arise.

Reports

The data submitted by Contributors to the IFRP will be analyzed and reported to the Contributor in a standard manner. These analyses will enable the Contributors to recognize trends in patient characteristics and to compare methods and complications of delivery and duration of hospital stay. The analyses will also facilitate the writing of reports, including the annual report of your maternity service.

Unlike some other IFRP studies, there are no queries sent to the Contributor who completes the Maternity Record Summary. Incomplete or inconsistent data are automatically changed to "unknown" by the computer. The report that the Contributor receives will specify the percentage distribution of all responses that are unknown or are converted to unknown, and the percentage of unknowns for each item will be shown in the standard analysis tables. It is, therefore, incumbent upon the Contributor himself to maintain a high standard of reporting and keep the number of inconsistent and missing responses to a minimum.

If data for a few specific items (see page 2) are missing or inconsistent, the entire form will be rejected by the computer. In this event the form will be returned to the Contributor, who may then correct the form and, if he wishes, return it to the IFRP with his next shipment of forms. If the computer then accepts it, the data will be loaded and will appear in the standard analysis tables. The standard analysis tables will be based only on forms accepted by the computer.

The Contributor must remember that cases that are not reported to the IFRP will not be included in the standard analysis tables, and that these tables are complete only if the data submitted to the IFRP are complete. If the Contributor fails to report a delivery, or does not correct and return an unacceptable form, these cases will be omitted from the standard analysis tables.

Inclusion of patients

The Maternity Record Summary (Appendix A) is completed for all women who are admitted to and who subsequently deliver at the hospital during this admission. Women should be included in the study regardless of the outcome of the delivery: mature or premature live birth, single or multiple birth or stillbirth.

Do not include patients who are admitted in false labor. If the same patient later returns, however, and is delivered in the hospital, the Maternity Record Summary should be completed for her at that time.

Do not include a patient with a molar pregnancy.

Do not include any patient admitted for an induced abortion. Do not include patients admitted for spontaneous abortion of a fetus weighing less than 500 grams, or if the fetus is not weighed, with an estimated gestation of less than 20 completed menstrual weeks.

Do not exclude patients who die and patients who deliver on weekends or holidays.

The Maternity Record Summary should be completed for all births occurring at the Center during the reporting period. The following definition of birth is used in this manual: the complete expulsion or extraction of a fetus from its mother whether the umbilical cord has been cut or not, or the placenta is attached. Do not re-

cord as births fetuses weighing less than 500 grams. In the absence of a measured birth weight, a gestational age of 20 completed weeks (since the onset of the last menstrual period) is considered equivalent to 500 grams. When neither birth weight nor gestational age is known, a body length (crown to heel) of 25 centimeters is considered equivalent to 500 grams. Although in the past (and still in some countries today) an infant weighing 1000 grams or less (28 weeks of gestation) was not considered viable, improved standards of neonatal care mean that some infants weighing as little as 500 grams (20 weeks of gestation) are viable and this is generally thought to be a more appropriate definition for today's maternity care. This definition of a birth is now generally accepted internationally and is approved by the International Federation of Gynaecology and Obstetrics. The Contributor is urged to accept these definitions for his study. If births are defined by some other criteria, the Contributor should remember that the standard analysis tables provided by the IFRP will include all acceptable forms submitted according to definitions in this manual.

A Contributor who is also completing the IFRP's Hospital Abortion Record Summary should make sure that every termination of pregnancy is reported on either the Hospital Abortion Record Summary or the Maternity Record Summary, and that no case is reported on both forms. The Contributor must decide which form to complete, based on the suggestions made in this section.

Deaths

A Death Report must be completed for every patient who dies after admission to the obstetric ward, even if the death occurs on another ward.

If a patient is admitted in labor and dies before delivery of the fetus, a Maternity Record Summary should be completed. This is the only situation in which a Maternity Record Summary should be completed for a patient with no delivery.

A few Death Reports are sent at the initiation of every Maternity Record Study. If additional forms are needed, please write to the appropriate Regional Coordinator at the IFRP.

Confidentiality

The Maternity Record Summary contains a section for personal identification data on each patient. The contributing Center retains this section. It will not be reported to the IFRP, will not be included in the statistical reports and will not be used in any manner by the IFRP.

II. INSTRUCTIONS FOR HANDLING PATIENT RECORD FORMS

Completing the forms

The forms should be completed with a ball-point pen in the same language as the form you are using. No carbon paper is necessary since the writing on the original (top sheet) is transferred by chemical process to the duplicate. In order to avoid marking more than one form at a time, remove each form and its duplicate from the pile before completing it, or place cardboard under the top form. The top sheet should be sent to the IFRP and the second sheet kept for hospital records.

It is essential that the person who completes the forms thoroughly understand each question. Every attempt should be made to obtain correct information for each item. Where it is appropriate, the interviewer should ask the patient direct and objective questions. When direct questioning fails, the response should be estimated as accurately as possible, using allied information.

Patient order number

The first patient in the study should be given patient order number 00001, and patient order numbers should subsequently be assigned in sequence. Care should be taken to avoid duplicate patient

order numbers. Forms should be returned to the IFRP in numerical order.

Checking the completed forms

Someone other than the person who originally completed the form should check the completed form to ensure that all information is correct and complete.

Special attention should be paid to the following items:

- 21. Estimated duration of pregnancy
- 22. Type of labor
- 24. Type of delivery
- 25. Primary complication of labor and/or delivery
- 28. Sex of infant(s) born at this delivery
- 31. Death of fetus/newborn
- 32. Primary puerperal condition

Forms in which these data are missing or are inconsistent with other items will not be accepted and will be returned to the Contributor.

Do not separate the original from the duplicate until all items on the form are recorded.

Separating the forms

After the forms have been completed and checked for accuracy, the originals (top sheets) should be carefully separated from the duplicates by tearing along the perforated line at the top of the sheet (below Item 4 and above Items 5 and 24). The Center should keep the Patient Identification section of the original as well as the entire duplicate.

Original copy batching

The original of each Maternity Record Summary, excluding the top portion marked Patient Identification (Items 1-4), should be collected to become part of a monthly shipping batch. A batch is a group of original, completed Maternity Record Summaries in numerical order that is forwarded to the IFRP for computer processing. Each batch is to be accompanied by one Shipping Control Sheet (Appendix B). All original forms—completed, incomplete, spoiled and unused—must be returned to the IFRP.

Shipping

On the first day of every month all completed Maternity Record Summaries from the previous month and a Shipping Control Sheet should be airmailed to the following address:

International Fertility Research Program
Research Triangle Park
North Carolina 27709 USA

For shipping instructions, see Appendix B.

III. GENERAL INSTRUCTIONS FOR COMPLETING THE MATERNITY RECORD SUMMARY

Range of responses

The categorized responses to items are intended to cover a broad range of possibilities not limited to the characteristics peculiar to any one geographical area. Thus, while some items may not be completely applicable to some local situations, it is extremely important that all items be completed as accurately and as consistently as possible.

Completing the boxes

Use only Arabic numerals. Alphabetic or other characters may not be used. Never write two numbers in one box, but be sure to write one number in each box.

For example, on the Maternity Record Summary, two boxes have been given for the response to Item 12—Total live births. If the response is ten, it will be coded as:

1	0
---	---

If, on the other hand, the response is three, it will be coded as:

0	3
---	---

For items that have several possible responses it is helpful to circle the number corresponding to the appropriate choice, but remember that the number must also be written in the box. The number recorded in the box is used for analysis.

If a number is incorrectly recorded in a box and cannot be corrected legibly within the box, cross out the number in the box and write the correct number in the margin beside the box.

"Unknown" responses

When, for any reason, the answer to an item is unknown, the person completing the Maternity Record Summary should write 9 in the corresponding box. Where there is more than one box for the response, 9 must be written in each box. For example, after Item 17—Number of months since last pregnancy ended—there are two boxes. If the time since last pregnancy is unknown, the response would be written as:

9	9
---	---

Exceptions to this rule will be explained under the instructions for those questions to which they apply.

Avoiding the use of "unknown" responses

If the form is completed while the patient is present, there is almost no reason for an "unknown" response. When a patient refuses or is unable to answer a particular question, an "unknown" response is justified. Contributors who routinely have large numbers of "unknown" responses will not have complete and comparable data for analysis.

Inconsistent responses

When the responses to two or more items are not consistent with each other, the response to some or all of the items will be changed automatically to unknown. For some items this will result in complete rejection of the form.

Numbers following answer boxes

The numbers that follow the answer boxes can usually be ignored; for example:

5. Center name _____ and number:

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 1-3

The computer keypunch operator uses these numbers in transcribing responses from the form to computer cards. They have no significance for the person completing the form except in a few questions; for example, for Items 13, 28 and 29 there are two responses, each one recorded in a separate box.

Recording the dates

Write the numbers corresponding to the date in the Gregorian calendar year. The order of the date should be day, month and year.

For example, in Item 8—Delivery date—the date April 6, 1978 should be recorded as:

0	6	0	4	7	8
day		month		year	

A Western calendar should be kept at the Center for ready reference to record or convert local dates to the Western (Gregorian) dates.

Codes for months:

January	= 01	July	= 07
February	= 02	August	= 08
March	= 03	September	= 09
April	= 04	October	= 10
May	= 05	November	= 11
June	= 06	December	= 12

Recording data on multiple births

Several questions on the Maternity Record can be answered for more than one baby in the case of a multiple birth. All the questions of this type (ie, 23, 27, 29, 30) refer to the baby delivered by the method described in Item 24. Item 24 refers to the most difficult delivery. When none of the births can be designated "most difficult," all responses to items should refer to the firstborn infant.

For details on recording data for multiple births, see instructions for coding Items 23, 27, 29 and 30 on pages 6 through 8.

Whenever there is a multiple birth, complete a Multiple Birth Record (Appendix E) for each baby.

NOTE: If any of these instructions are not clear or do not appear consistent with your particular situation, write to the IFRP to request clarification before initiating the study.

IV. COMPLETING THE MATERNITY RECORD SUMMARY

Patient Identification Items 1-4

Information on Items 1-4 will not be mailed to the IFRP, but will be retained by the Center.

1. Hospital or clinic no. _____

This is the hospital or clinic registration number assigned to the patient.

This patient number is for internal use by the hospital/clinic. It is an important means of locating missing information that may be requested by the IFRP.

2. Admission date _____
day month year

Record the day, month and year in Arabic numerals in the space provided. For example, April 6, 1978 should be recorded as:

0	6	0	4	7	8
day		month		year	

Admission date is the date on which the patient was admitted to the hospital.

If the patient is admitted to the hospital on one day, remains in the hospital overnight and is delivered the following day, the Admission date is the day before delivery. Therefore, Item 8—Delivery date—may or may not be the same as the admission date.

3. Patient's name _____

Husband's name _____

4. Address _____

This information is for internal use by the hospital/clinic.

Study Identification Items 5-11

5. Center name _____ and number:

9	2	1
---	---	---

 1-3

Write the Center name in the space provided.
Each participating Center is assigned a unique three-digit number. These three digits should be recorded in the space provided. For example, Center number 921 is recorded as:

9	2	1
---	---	---

 1-3

This item may be completed before the patient is admitted to the study.

6. Study number:

9	1	0
---	---	---

 4-6

Each study is assigned a unique three-digit number which will be recorded in the three boxes provided.

Study numbers are assigned by the IFRP. Special studies may be undertaken from time to time; for such studies, contact the IFRP for assignment of a special study number.

7. Patient order number:

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 7-11

Each patient must be given a unique patient order number.
Patient order numbers should start with 00001 and be assigned consecutively. A system should be developed at the Center to ensure that no two patients are assigned the same number and no number is missed.

The patient order number cannot be more than five (5) digits long.

The completed forms should be checked for missed or duplicate patient order numbers. Provision should be made at the Center for cross-reference of patient order number and corresponding hospital or clinic patient number for possible future queries. Refer to the subsection, **Separating the forms**, in Section II, **Instructions for Handling Patient Record Forms**.

8. Delivery date:

--	--

 day

--	--

 month

--	--

 year 12-17

This refers to the date on which the infant was delivered. It may be different from the date of admission.

9. Patient's age: (completed years)

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 21-22

Write the exact number of years completed since birth.

If the patient does not know her age, the clinician should estimate her age from visual and other evidence.

10. Patient's education: (school year completed) 0) 0
1) 1-2 2) 3-4 3) 5-6 4) 7-8 5) 9-10 6) 11-12
7) 13-14 8) 15+

--

 23

Write in the box the number corresponding to the correct category of school year completed. This refers to the level of formal education, including primary, high school, university, professional schools, trade schools, business schools, but not such training as

apprentice training. It does not refer to the total number of years spent in school in order to attain a particular level. For example, if the patient took two years to complete the fifth grade and did not continue studying, the number of school years completed by her is five years. Do not count years spent in preschool, nursery school, or kindergarten. This item has to be answered according to the educational structure of the given country. Some examples follow for clarification:

• **EXAMPLE:** The educational structure of a country is six years of primary school, five years of secondary school and university. Trade school requires the completion of primary school. Business school requires the completion of three years of secondary school. Therefore:

- If the patient completed primary school and two years in trade school, write **4** in the box.
- If the patient completed primary school, the first year of secondary school, and two years in trade school, write **5** in the box.
- If the patient completed primary school, secondary school and two years of business school, write **7** in the box.
- If the patient completed one year of nursery school and three years of primary school, write **2** in the box.
- If the patient attended primary school for five years but only completed the third level of the educational system, write **2** in the box.
- If the patient has no formal education, write **0** in the box.

11. Age at first marriage/union (completed years)

 25-26

- In countries where the marriage ceremony precedes the consummation of the marriage by some time (usually in the case of very young brides), the age when the sexual union was established should be recorded.
- Where the patient has been married more than once, record the age of the first marriage or union.

Obstetric History Items 12-18

NOTE: Items 12-18 refer to the outcomes of all pregnancies other than the current pregnancy and its termination.

12. Total live births:

 27-28

- Live birth is defined as the process of birth of an infant weighing 500 grams or more and with any sign of life, regardless of the subsequent outcome. In the absence of known birth weight, 20 or more completed menstrual weeks of gestation (calculated from the first day of the last normal menstrual period) is considered equivalent to 500 grams or more birth weight.
- Write the number of live births in the boxes.
- Record each infant in a multiple birth as an individual birth.
- If the patient has not previously given birth to live children, write **0** in each of the boxes.
- **NOTE:** The response for this item should not be less than the sum of the responses in Item 13.

13. Children now living:

number of males
(8 or more = 8)
number of females

 29
 30

- This item refers only to children born to this patient and does not include adopted children or her husband's children by any other wife.
- The number of Item 13—Children now living—does not necessarily equal Item 12—Total live births. The number of children now

living can never exceed the number of total live births.

- Write the number of living male and living female children in the appropriate box.
- If there are no living male or female children, write **0** in the appropriate box.
- If there are eight or more living male or female children, write **8** in the appropriate box.

14. Duration of breast-feeding of last live birth:

0) did not breast-feed 1) <3 months 2) <6 3) <9
4) <12 5) <15 6) <18 7) <21 8) ≥21 months

 31

- Record the duration of breast-feeding of the last child who was born alive even if that child is no longer living.

EXAMPLE: If the patient breast-fed the last child for four months, record **2** in the box, ie, at least three but less than six completed months.

15. Number of stillbirths: (8 or more = 8)

 32

- Stillbirth is defined as the process of birth of a fetus weighing 500 grams or more (equivalent to 20 menstrual weeks' gestation) with no evidence of life after birth.
- Write in the box the total number of previous pregnancies terminated in stillbirth.
- If there were eight or more previous stillbirths, write **8** in the box.

16. Outcome of last pregnancy: 0) not previously pregnant

1) live birth, full term, still living 2) live birth, full term, deceased 3) live birth, premature, still living 4) live birth, premature, deceased 5) stillbirth 6) induced abortion 7) spontaneous abortion 8) other

 36

- Care should be taken that the response to this item is consistent with responses to Items 12 and 15.
- Live birth (See Item 12).
- Full term is defined as any infant delivered at 37 or more completed menstrual weeks of gestation. (This includes "post-term" infants of 42 or more completed weeks of gestation.)
- Premature is defined as any infant delivered at less than 37 weeks of gestation.
- Stillbirth (See Item 15).
- Induced abortion is defined as the artificial (willful or intentional) termination of any pregnancy before viability of the fetus.
- Spontaneous abortion is the expulsion from its mother of a fetus or embryo weighing less than 500 grams (equivalent to 20 completed menstrual weeks of gestation) or other product of gestation of any weight (eg, hydatidiform mole) irrespective of gestational age, without willful interference even if a curettage or other interference was subsequently used to complete the abortion. "Miscarriages" are to be reported in this item.
- If the last pregnancy was ectopic or molar, write **8** in the box.

17. Number of months since last pregnancy ended:
(98 or more = 98)

 37-38

- Write in the boxes the number of months since the termination of the last pregnancy, whether it was the delivery of an infant, an abortion or surgical intervention for an ectopic pregnancy.
- If the last pregnancy was terminated more than eight years ago, write **98** in the boxes.
- If the current pregnancy is the woman's first, write **00** in the boxes.

18. Contraceptive method mainly used before conception:
 0) none 1) IUD 2) orals/injectables 3) female sterilization
 4) male sterilization 5) condom 6) withdrawal/rhythm
 7) foam/diaphragm/jelly 8) other _____ 39

- Write in the box the number corresponding to the contraceptive method *most* frequently used *before conception*.
- IUD: any intrauterine contraceptive device.
- Orals/injectables: oral contraceptive pills or injections of such substances as Depo-Provera (medroxyprogesterone acetate).
- Female sterilization: any operation intended to cause permanent sterilization of the female partner.
- Male sterilization: any operation intended to cause permanent sterilization of the male partner.
- Condom: male sheath.
- Withdrawal/rhythm: coitus interruptus/safe period. (Even if the patient has been using these methods incorrectly, write **6** in the box.)
- Foam/diaphragm/jelly: modern or traditional spermicidal preparations applied intravaginally or an intravaginal diaphragm or both.
- Other: In the space provided, write the name of any other contraceptive method, such as douche, commonly used by the couple. If a brand name is used, specify the type of contraceptive. Do not include such methods as lactation amenorrhea.

Medical Data Items 19-26

19. Primary antenatal condition: 00) none 02) placenta previa 06) antepartum hemorrhage 10) preeclamptic toxemia 11) eclampsia 14) urinary tract infection 29) anemia 35) incompetent cervix 79) diabetes 98) other _____ 41-42

- If the patient's antenatal condition is normal and satisfactory, write **0** in each of the boxes.
- If the antenatal conditions are unknown, write **9** in each of the boxes.
- Record the antenatal condition as specifically as possible.
- If the patient has more than one antenatal condition, record the one that has the greatest clinical significance for the mother, rather than the fetus.
- Placenta previa: Only placenta previa diagnosed antenatally should be recorded. If the condition is not diagnosed until the onset of labor, this should be recorded under Item 25, code 2. Placenta previa is the implantation of any part of the placenta in the lower uterine segment. The term expresses the anatomic relationship between the placental site and the lower uterine segment. The placenta encroaches on or covers (completely or partially) the internal cervical os. This code includes low-lying placenta, marginal, partial and total placenta previa with or without hemorrhage.
- Antepartum hemorrhage: Any antepartum bleeding of uterine origin that is *not* associated with placenta previa should be recorded here. Record the bleeding whether the etiology is known or not.
- Preeclamptic toxemia: Preeclampsia or preeclamptic toxemia is defined as the development of hypertension with proteinuria or edema or both and which is attributed to the pregnancy. It includes both mild and severe cases.
- Eclampsia: Eclampsia is characterized by convulsions in a patient with preeclampsia that cannot be attributed to a condition such as epilepsy.
- Urinary tract infection: This includes all infections of the urinary tract from the kidney to the urethra.
- Anemia: This condition is characterized by small, pale red blood cells, low reticulocyte activity and depleted iron reserves. Serum iron concentration is below 60 µg/100 ml. Folic acid deficiency, megaloblastic anemia and other deficiency anemias, either ac-

quired or hereditary, should be included. Sickle cell anemia and thalassemia should also be recorded.

- Incompetent cervix: This condition can be inferred from a painless dilation and effacement of the cervix, usually in the second trimester, or from a history of repeated, relatively painless and bloodless second trimester abortions. If the condition is diagnosed, this code should be used regardless of whether or not surgical repair has been done.
- Diabetes: Both gestational and preexisting diabetes should be recorded.
- If in doubt, write to the IFRP and request a code assignment.
- If necessary, specify any details of the condition or any additional conditions on the back of the form.

20. Number of previous cesarean sections: 43

- Write in the box the number of cesarean sections before this pregnancy.
- If the patient has had more than eight cesarean sections previously, write **8** in the box.
- Do not include cases where there was laparotomy in order to repair uterine rupture.

21. Estimated duration of pregnancy:
 (menstrual age in completed weeks) 46-47

- If this item is recorded **99** (unknown), the form will be rejected and returned to the Contributor.
- Duration of pregnancy is the number of completed weeks from the onset of the patient's last normal menstrual period to the day of delivery. If the date of the last menstrual period is unknown, estimate it from clinical evidence such as fundal height or fetal head size.

22. Type of labor: 0) no labor 1) spontaneous 2) spontaneous, augmented with artificial rupture of membranes (ARM) 3) spontaneous, augmented with drugs 4) spontaneous, augmented with ARM and drugs 5) induced, with ARM 6) induced, with drugs 7) induced, with ARM and drugs 8) other _____ 30

- If this item is recorded **9** (unknown), the form will be rejected and returned to the Contributor.
- If a patient has no labor, such as a woman undergoing elective cesarean section, write **0** in the box.
- Spontaneous labor is defined as labor that began without intervention, even if it is later augmented by intervention. If the patient's labor was spontaneous, write **1**, **2**, **3** or **4** in the box.
- Induced labor is defined as labor initiated by the birth attendant by administering drugs (usually oxytocics), by artificially rupturing the membranes, or by both. If the patient's labor was induced, write **5**, **6** or **7** in the box.
- If labor follows the administration of enemas or cathartics, do not record it as induced or augmented.
- If labor started spontaneously, but drugs were given or amniotomy performed to accelerate it, record it as spontaneous, not induced, labor.

Recording data on multiple births

Several questions on the Maternity Record Summary can be answered for more than one baby in the case of a multiple birth. All the questions of this type (ie, 23, 27, 29 and 30) refer to the baby who is delivered by the method described in Item 24. Item 24 refers to the most difficult delivery. When none of the births can be designated "most difficult," all responses to items should refer to the firstborn infant.

Complete an IFRP Multiple Birth Record for each baby.

EXAMPLES:

- A twin delivery in which the firstborn is in the vertex position and is delivered spontaneously, and the second is in the breech position and is delivered with forceps to the aftercoming head. All items will refer to the second twin.
- A twin delivery in which both infants are in the vertex position and both are delivered spontaneously. All items will refer to the first twin.
- A triplet delivery in which the first two babies are delivered spontaneously at home, the third is retained *in utero* and delivered by cesarean section in hospital. All items refer to the infant delivered in hospital.

23. Type of presentation during labor: 0) vertex, occiput anterior 1) vertex, occiput transversa or posterior 2) breech, frank 3) breech, footling 4) complete breech 5) brow/face 6) transverse lie 7) compound 8) other _____



● **Frank breech**, also known as single breech or pelvic presentation

• The presentation of the infant whose delivery is recorded in Item 24 should be recorded here. Usually this will also mean the most difficult presentation.

• The type of presentation during labor should be recorded. This is not necessarily the same as the presentation at delivery. If a malpresentation is corrected, either spontaneously or by version or rotation, so that delivery is normal vertex, then the malpresentation should be recorded.

• Frank breech, also known as single breech or pelvic presentation.

• Footling breech, also known as incomplete breech. Note that both double footling (both feet or knees are prolapsed into the vagina) and single footling (one foot or knee is prolapsed into the vagina) are included in this category.

• Complete breech, also known as double breech, full breech or flexed breech.

• Transverse lie refers to oblique and "back-up" and "back-down" transverse lies.

• Compound presentation means that more than one part, such as the arm and vertex, presented.

• Cord prolapse should be recorded as 8) **other**, writing "cord prolapse" on the line.

24. Type of delivery: 0) spontaneous 1) outlet forceps 2) vacuum extractor 3) mid- or high forceps 4) manual rotation 5) breech extraction 6) cesarean section 7) destructive procedure 8) other _____



● **Footling breech**, also known as incomplete breech. Note that both double footling (both feet or knees are prolapsed into the vagina) and single footling (one foot or knee is prolapsed into the vagina) are included in this category

• Spontaneous delivery is one in which the birth attendant does not assist beyond holding the baby, or in which the birth attendant facilitates the delivery manually. Do not include major manual maneuvers such as rotation or version.

• Outlet forceps (low forceps) delivery means that the forceps are applied when the scalp is or has been visible at the introitus without separating the labia, the skull has reached the pelvic floor and the sagittal suture is in the anteroposterior diameter of the pelvis.

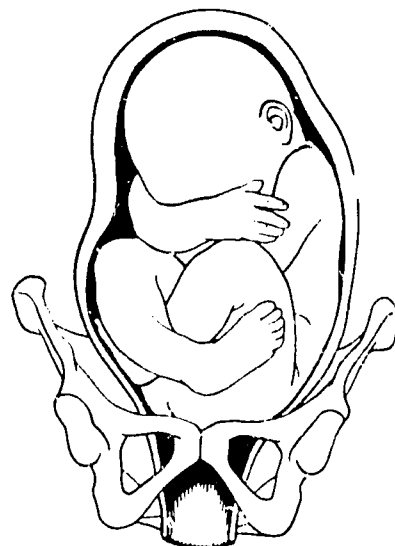
• Vacuum extractor refers to the use of a cup from which the air is partially evacuated after it has been placed over the infant's head.

• Mid- or high forceps delivery means that the forceps are applied when the head is engaged (mid-forceps) or not engaged (high forceps), but the conditions for outlet forceps delivery have not been met. Any forceps delivery requiring artificial rotation beyond 45°, regardless of the station from which the extraction is begun, is designated mid-forceps delivery.

• Manual rotation means a major manual maneuver such as rotation beyond 45°. Do not include either internal or external version in this code. These should be coded as 8) **other**.

• Breech extraction includes all maneuvers to assist the delivery of the baby, including manual maneuvers to deliver the head. If the

● **Complete breech**, also known as double breech, full breech or flexed breech



infant is delivered with no assistance from the birth attendant, the delivery should be recorded as **0) spontaneous**. If forceps are applied to the aftercoming head, the delivery should be recorded as **1) outlet forceps**.

- Cesarean section includes classical, low transverse, and extra-peritoneal cesarean section and other abdominal methods of delivery. However, if there is uterine rupture and the infant is delivered by laparotomy, write **8) other** in the box and describe the situation in the space provided. Do not record it as a cesarean section.

- Destructive procedures include craniotomy, embryotomy, decapitation and any procedure which involves deliberate mutilation and death of the fetus, whether the fetus was alive or dead before the procedure.

- Other includes such situations as internal or external version or symphysiotomy. It also includes laparotomy for uterine rupture as mentioned above. Any method of delivery that cannot be accommodated by codes **0-7** should be recorded as **8** and details given in the space provided.

- 25 Primary complication of labor and/or delivery: 0) none 1) prolonged/obstructed labor 2) placenta previa 3) placenta abruptio 4) hypotonic uterine contractions 5) hypertonic uterine contractions 6) hemorrhage 7) retained products 8) other _____

 50

- If there is more than one complication, use the following principles to decide which one is primary.
- Record the clinically most important condition, that is, the potentially most hazardous one.
- If, of the two or more conditions, one threatens the mother and one the fetus, record the one that threatens the mother.
- If both a symptom and a diagnosed condition are to be recorded, record the diagnosed condition.

EXAMPLES:

- For hemorrhage and retained products, record retained products.
- For placenta previa and hemorrhage, record placenta previa.
- For hypotonic uterine contractions and prolonged labor, record hypotonic contractions.

- For obstructed labor and prolonged labor, record the obstruction here.

- **NOTE:** Placenta previa, placenta abruptio and obstructed labor are always to be recorded as the primary complications.

- Prolonged labor is defined for this study as active labor of more than 18 hours.

- Obstructed labor is the lack of adequate progress of labor because of cephalo-pelvic disproportion, the presence of pelvic masses or fetal size, shape, abnormalities or presentation.

- Placenta previa is the implantation of the placenta in the lower uterine segment. The placenta encroaches on or covers (completely or partially) the internal cervical os. Placenta previa is classified as marginal, partial or total, and all forms should be recorded here.

- Placenta abruptio is the complete or partial detachment of the normally implanted placenta from the uterine wall at 20 completed weeks or more of gestation.

- Record placenta abruptio in both its complete and incomplete forms and also situations where only the placental margin is involved (marginal sinus rupture).

- Hypotonic uterine contractions (hypoactive uterine inertia) are those which are less than normal in intensity and/or frequency for that stage of labor.

- Hypertonic uterine contractions (hyperactive uterine inertia) are those which exceed the normal pattern of intensity and/or frequency for that stage of labor.

- Hemorrhage is the loss from the vascular space of more than 500 ml of blood irrespective of the etiology or whether it is external or in-

ternal blood loss. Record the etiology of the blood loss in the space provided.

- Retained products is the failure to completely expel the placenta and membranes within one hour of the delivery of the fetus, or failure to expel the second twin within 12 hours of the first infant.

- If the placenta is removed manually or surgically within one hour of delivery, do *not* code as retained products.

- Any complication that occurs that cannot be accommodated by the above codes should be described in the space provided, and **8** written in the box.

- 26 Attendant at delivery: 0) none 1) nurse 2) qualified midwife 3) student nurse/midwife 4) paramedic 5) medical student 6) general physician 7) OB/GYN physician 8) other _____

 51

- Record the appropriate number in the box.
- If more than one person attends the birth, record the person primarily responsible for the delivery.
- Midwife is defined as a nurse who has had special obstetric training. Do not include untrained midwives.
- If the birth attendant was a student nurse or student midwife, write **3** in the box; if it was a medical student, write **5** in the box. Medical student is defined as a person who has not yet received a medical degree (MD, MB, ChB, etc).
- Paramedic refers to any person with medical training who is not a nurse, midwife, physician or medical student.
- General physician refers to any person who has a medical degree and no specialized training in obstetrics and gynecology.
- OB/GYN physician refers to any person who has a medical degree and has or is receiving specialized training in obstetrics and gynecology.
- Other includes any person who was the primary birth attendant and fits into none of the above categories, such as a social worker, a policeman or a relative of the patient.

Pregnancy Outcome Items 27-32

- 27 Birth weight in grams

 52-53

- **NOTE:** Do NOT estimate weight.
- Record in grams the infant's weight within one hour of delivery. Do not include the weight of cord clamps, swaddlings, etc. A conversion table from pounds and ounces to grams is given in Appendix C. Record the weight of all infants, including those stillborn. In the case of multiple births, the weight of the infant whose delivery is recorded in Item 24 should be recorded here.
- If weighing scales are not available or the infant was not weighed for some other reason, write **9** in each of the four boxes.

EXAMPLES:

- For twins, when the spontaneously delivered firstborn weighs 1504 grams and the forceps delivered secondborn weighs 1753 grams, record **1753** in the boxes.
- If the weight equals or exceeds 9988 grams, record **9988**.

- 28 Sex of infant(s) born at this delivery:

number of males
(write number of each)
number of females

 63
 64

- Record the number of infants of each sex delivered, both live births and stillbirths. For example, if one male child is delivered, write **1** in box 63 and **0** in box 64.
- For multiple births, complete a Multiple Birth Record for each infant.

• **NOTE:** If either of these two boxes is blank, the entire form will be rejected and returned to the Contributor.

• **NOTE:** Items 29 and 30 refer to Item 24 delivery.

29. Apgar score: 9) not done at 1 minute
(8 or more = 8) at 5 minutes

65
66

• The Apgar score is a system of numerical evaluation that describes the status of the infant at one minute and five minutes after birth. A score of zero indicates a severely jeopardized infant; higher scores, up to a maximum of 10, indicate progressively better conditions. The score should be given by someone other than the one who delivers the infant so that each measurement can be obtained objectively. The one-minute and five-minute intervals after birth must be timed.

• Each sign is given a score and the total of the five scores is the Apgar score. Record this number in the box. If the score is 8, 9 or 10, write 8 in the box.

APGAR SCORE

Criteria and Values				
Sign	2	1	0	Score
Heart rate	≥ 100	< 100	absent to auscultation	
Respiration	yelling	irregular, inadequate	none	
Muscle tone	well flexed	some tone	flaccid	
Reflexes-sharp slap on feet	cry	grimace	none	
Color	pink all over	blue hands and feet	pale blue	
Total				

30. Primary fetal/neonatal condition: 0) normal, or stillbirth with no apparent pathology 1) fetal distress during labor 2) minor malformation 3) major malformation 4) respiratory distress syndrome 5) isoimmunization 6) neonatal sepsis 7) trauma 8) other For codes 2), 3), 7), 8), specify _____

67

• If the infant is normal and liveborn, or is stillborn with no apparent pathology, write 0 in the box. Please do NOT code a stillbirth as 8 in this box. We can learn from Item 31 whether the infant is liveborn or stillborn.

• Fetal distress during labor includes such indications as deceleration of heart rate to less than 100 beats per minute, or a fetal scalp pH of less than 7.2. Write the indication of fetal distress in the space provided.

• Minor malformations are those which do not threaten fetal survival, such as polydactyly, syndactyly, pes equinovarus and luxation of the hip joint. Specify the malformation in the space.

• Major malformations are those which threaten the life and normal development of the newborn, such as hydrocephaly, myelomeningocele, cleft palate and congenital metabolic error. Specify the malformation in the space.

• Respiratory distress syndrome (or pulmonary syndrome or hyaline membrane disease) is characterized by expiratory grunting, labored respiration, thoracic/abdominal retraction, cyanosis and/or cardiac failure accompanied by metabolic disorder. Record only respiratory distress that requires treatment.

• Isoimmunization is the condition produced in the fetus as a result of exposure to maternal antibodies (for example, Rh, Hr, A-B and those designated in other blood classification systems).

• Do not include physiologic icterus of the newborn or cases in which the mother has antibody titers that do not produce changes in the fetus/neonate requiring therapy.

• Icterus (yellow sclera) is considered pathologic when the serum bilirubin level is 8.0 mg/100 ml serum.

• Neonatal sepsis is a systemic response to any infection.

• Trauma means mechanical injury occurring during delivery, such as a laceration from use of forceps or a broken clavicle (whether accidental or intentional to facilitate delivery). On the line provided, specify all details when trauma occurs. Do not include destructive procedures used to deliver the fetus and recorded in Item 24.

• If the infant's neonatal condition is not covered by any of the above conditions, write 8 in the box and describe the condition in the space provided

31. Death of fetus/newborn: 0) none 1) antepartum, one 2) antepartum, two or more 3) intrapartum, one 4) intrapartum, two or more 5) postpartum, one 6) postpartum, two or more 7) combination 8) other _____

69

• Record in this box the appropriate code for the number of fetal and neonatal deaths that occur before the mother is discharged from the hospital.

• If there is a multiple birth of three or more infants and more than one dies, write in the margin how many died.

• Antepartum means before the onset of labor.

• Intrapartum means during labor and before the infant is completely expelled from the mother.

• Postpartum means after the infant is completely expelled and separated from the mother until mother's discharge from the hospital.

• **NOTE:** Codes 2, 4, 6 and 7 cannot exist for a single delivery. If these responses are used with a single delivery, the entire form will be rejected and returned to the Contributor.

32. Primary puerperal condition: 0) normal 1) fever requiring treatment 2) bleeding requiring treatment 3) urinary tract infection 4) mastitis 5) phlebitis 6) dehiscence 7) death (complete Death Report) 8) other _____

70

• Write 0 in the box if the postpartum status is normal.

• Record the appropriate code if postpartum complications occur.

• Bleeding refers to bleeding occurring 24 hours or more after delivery.

• Urinary tract infection includes all infections of the urinary tract from the kidney to the urethra.

• Mastitis refers to inflammation of the breast. Do not include normal engorgement of the breast, even if accompanied by transitory fever.

• Phlebitis refers to any venous inflammation or clotting in the venous system of the legs or lower pelvis and includes superficial or deep phlebitis.

• Dehiscence refers to the separation or gaping of the incision, including episiotomy and cesarean section incisions.

• If the mother dies, complete a Death Report (Appendix D) and attach it to the Maternity Record Summary.

Special Studies: Items 33-35

- The Contributor may decide to include on this form up to three additional items which are recorded in the Special Studies section. All questions, codes, and definitions are at his own discretion, although the IFRP may make recommendations. The IFRP must approve the use of all Special Studies before the study is initiated.

SPECIAL STUDIES	
33 _____	<input type="text"/> 73
34 _____	<input type="text"/> 74
35 _____	<input type="text"/> 75

Recorder's name _____

1 80

- The person who completes the Maternity Record Summary should write his/her name legibly on this line.

Additional Information Items 36-38**COMPLETE THESE ITEMS AT TIME OF DISCHARGE**

36. Female sterilization: 0) none 1) before this delivery
 2) at cesarean section 3) immediately after delivery
 4) same day 5) 1-2 days later 6) 3-4 days later
 7) 5-9 days later 8) 10 or more days later

 77

- Write 0 in the box if the patient was not sterilized during her hospitalization for delivery. If the patient was sterilized before delivery, write 1 in the box. If the patient was sterilized during a cesarean section, write 2 in the box. Otherwise, write in the box the code corresponding to the number of days after delivery the patient was sterilized. Immediately after delivery is defined as within two hours of delivery.

- Any operation which causes permanent sterilization should be recorded here. However, if the patient is not sterilized during the admission in which she delivered, even if she intends to return or does return after discharge for such an operation, do not record it in this item.

- If an operation which produces permanent sterilization was performed, but not for contraceptive purposes (for instance, hysterectomy following a ruptured uterus), it should be recorded in this item.

- If the patient died before discharge, write 9 in the box.

37. Number of additional children wanted: (8 or more = 8)

 78

- An effort should be made to obtain a realistic statement of the number wanted. If the patient wants more children, but does not know how many, write 8 in the box. If she wants as many as possible or whatever God sends, write 8 in the box.

- If the patient died before discharge, write 9 in the box.

38. Contraceptive method planned or provided: 0) none

- 1) IUD 2) orals/injectables 3) female sterilization
 4) male sterilization 5) condom 6) withdrawal/rhythm
 7) foam/diaphragm/jelly 8) other _____

 79

- Record in the box the number corresponding to the method of fertility control used by the patient at her discharge, or the method she plans to use after discharge. If at discharge she is not using any method of fertility control, record the method she plans to use.

- Use the definitions given in Item 18.

- If the response is "other," specify the method used or planned.

- If the patient intends to contracept but has not decided what method to use, write 9 (unknown) in the box.

- If the patient died before discharge, write 9 in the box.

- If the response to Item 36 is 1 through 8, the response to this item must be 3.

- If the patient is sterilized during this admission, write 3 in the box.

INTERNATIONAL FERTILITY RESEARCH PROGRAM

MATERNITY RECORD SUMMARY

Please circle appropriate choices and fill in boxes and blanks:

PATIENT IDENTIFICATION: 1 Hospital or clinic no. _____ 2 Admission date _____ day month year
 3 Patient's name _____ Husband's name _____
 4 Address _____

STUDY IDENTIFICATION

5 Center name _____ and number

9	1	0

 1-3
 6 Study number

 4-6
 7 Patient order number

 7-11
 8 Delivery date

 day month year 12-17
 9 Patient's age (completed years)

--	--

 21-22
 10 Patient's education (school year completed) 0-12
 1) 1-2 2) 3-4 3) 5-6 4) 7-8 5) 9-10 6) 11-12 7) 13-14 8) 15+
 11 Age at first marriage (completed years)

--	--

 23-25

OBSTETRIC HISTORY (not including this pregnancy)

12 Total live births

--

 27-28
 13 Children now living

--

 number of males (8 or more = 8) 29

--

 number of females 30
 14 Duration of breast feeding of last live birth
 0) did not breast feed 1) 1-3 months 2) 4-6 3) 7-9 4) 10-12 5) 13-15 6) 16-18 7) 19-21 8) 22+ months

--

 31
 15 Number of stillbirths (8 or more = 8)

--

 32
 16 Outcome of last pregnancy: 0) not previously pregnant 1) live birth, full term, still living 2) live birth, full term deceased 3) live birth, premature, still living 4) live birth, premature, deceased 5) stillbirth 6) induced abortion 7) spontaneous abortion 8) other

--

 35
 17 Number of months since last pregnancy ended (98 or more = 98)

--	--

 37-38
 18 Contraceptive method mainly used before conception
 0) none 1) IUD 2) orals/injectables 3) female sterilization 4) male sterilization 5) condom 6) withdrawal/rhythm 7) foam/diaphragm/jelly 8) other

--

 39

MEDICAL DATA

19 Primary antenatal condition: 00) none 02) placenta previa 06) antepartum hemorrhage 10) preeclampsia/toxemia 11) eclampsia 14) urinary tract infection 29) anemia 35) incompetent cervix 79) diabetes 98) other

--	--

 41-42
 20 Number of previous cesarean sections

--

 43
 21 Estimated duration of pregnancy (menstrual age in completed weeks)

--	--

 46-47
 22 Type of labor: 0) no labor 1) spontaneous 2) spontaneous, augmented with artificial rupture of membranes (ARM) 3) spontaneous, augmented with drugs 4) spontaneous, augmented with ARM and drugs 5) induced, with ARM 6) induced, with drugs 7) induced, with ARM and drugs 8) other

--

 50

In case of multiple birth, record the most difficult delivery in items 23, 24, 27, 29 and 30, and complete a Multiple Birth Record for each child.

23. Type of presentation during labor: 0) vertex, occiput anterior 1) vertex, occiput transverse or posterior 2) breech, frank 3) breech, footling 4) complete breech 5) brow/face 6) transverse lie 7) compound 8) other

--

 51

24 Type of delivery: 0) spontaneous 1) outlet forceps 2) vacuum extractor 3) mid- or high forceps 4) manual rotation 5) breech extraction 6) cesarean section 7) destructive procedure 8) other

--

 54
 25 Primary complication of labor and/or delivery: 0) none 1) prolonged/obstructed labor 2) placenta previa 3) placenta abruptio 4) hypertonic uterine contractions 5) hypertonic uterine contractions 6) hemorrhage 7) retained products 8) other

--

 56
 26 Attendant at delivery: 0) none 1) nurse 2) qualified midwife 3) student nurse/midwife 4) paramedic 5) medical student 6) general physician 7) OB/GYN physician 8) other

--

 58
 27 Birth weight in grams

--	--	--	--

 60-62
 28 Sex of infant(s) born at this delivery

--

 number of males (write number of each) 63

--

 number of females 64
 29 Apgar score: 9) not done 1) at 1 minute (8 or more = 8) 65

--

 at 5 minutes 66
 30 Primary fetal/neonatal condition: 0) normal, or stillbirth with no apparent pathology 1) fetal distress during labor 2) minor malformation 3) major malformation 4) respiratory distress syndrome 5) isoimmunization 6) neonatal sepsis 7) trauma 8) other For codes 2), 3), 7), 8), specify

--

 67
 31 Death of fetus/newborn: 0) none 1) antepartum, one 2) antepartum, two or more 3) intrapartum, one 4) intrapartum, two or more 5) postpartum, one 6) postpartum, two or more 7) combination 8) other

--

 69
 32 Primary puerperal condition: 0) normal 1) fever requiring treatment 2) bleeding requiring treatment 3) urinary tract infection 4) mastitis 5) phlebitis 6) dehiscence 7) death (complete Death Report) 8) other

--

 70

SPECIAL STUDIES

33

--

 73
 34

--

 74
 35

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 75

COMPLETE THESE ITEMS AT TIME OF DISCHARGE

36 Female sterilization: 0) none 1) before this delivery 2) at cesarean section 3) immediately after delivery 4) same day 5) 1-2 days later 6) 3-4 days later 7) 5-9 days later 8) 10 or more days later

--

 77
 37 Number of additional children wanted: (8 or more = 8)

--

 78
 38 Contraceptive method planned or provided: 0) none 1) IUD 2) orals/injectables 3) female sterilization 4) male sterilization 5) condom 6) withdrawal/rhythm 7) foam/diaphragm/jelly 8) other

--

 79

Recorder's name

1

 80

PLEASE AIRMAIL TO: International Fertility Research Program, Research Triangle Park, North Carolina 27709 USA

MAT101-kkx146 9/78

Shipping Date _____

11

INSTRUCTIONS FOR THE SHIPPING CONTROL SHEET FOR MATERNITY RECORD STUDIES

Completed forms should be sent each month to the International Fertility Research Program. A Shipping Control Sheet (SCS) should be mailed *with* each package of forms sent. Please complete the SCS as follows:

Center Number Record the number assigned to your Center.

Shipping Date Record the date on which the forms are being sent.

Enclosure Information

1. **Shipment Number**—To help ensure that no shipments are misplaced or lost, each shipment of forms should be numbered consecutively within each specific study. If a break in the shipment number sequence is noted, the Contributor will be notified and attempts made to locate the missing shipment. If a shipment cannot be located, the Contributor's duplicate copies may be used to obtain the data.
2. **Study Number**—List the appropriate study number vertically in this column. Several studies may be listed on one Shipping Control Sheet. However, each separate package mailed should include a Shipping Control Sheet listing the contents of that package.

Enter the total number of each type of form sent in the appropriate column. Blank columns have been left to allow for a tally of any special forms that may be used.

Supplies Needed

The IFRP recommends that a large enough supply of forms be maintained by the Contributor, to cover a two to three month period. Since Center's volume may vary at different times throughout the study, this section is intended to help ensure against depleting the supply of forms during the study.

Address Change

If there is a change of contact person or address, please note the change at the bottom of the SCS.

CONVERSION CHART: Ounces to grams

		ounces														
lb	0	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
		28	57	85	113	142	170	198	227	255	283	312	340	369	397	425
1	454	481	510	539	567	595	624	652	680	709	737	765	794	822	850	879
2	907	936	964	992	1021	1049	1077	1106	1134	1162	1191	1219	1247	1276	1304	1332
3	1361	1389	1417	1446	1474	1503	1531	1559	1588	1616	1644	1673	1701	1729	1758	1786
4	1814	1843	1871	1899	1928	1956	1984	2013	2041	2070	2098	2126	2155	2183	2211	2240
5	2268	2296	2325	2353	2381	2410	2438	2466	2495	2523	2551	2580	2608	2637	2665	2693
6	2722	2750	2778	2807	2835	2863	2892	2920	2948	2977	3005	3033	3062	3090	3118	3147
7	3175	3204	3232	3260	3289	3317	3345	3374	3402	3430	3459	3487	3515	3544	3572	3600
8	3629	3657	3685	3714	3742	3771	3799	3827	3856	3884	3912	3941	3969	3997	4026	4054
9	4082	4111	4139	4167	4195	4224	4252	4281	4309	4337	4366	4394	4422	4451	4479	4508
10	4536	4564	4593	4621	4649	4678	4706	4734	4763	4791	4819	4848	4876	4904	4933	4961
11	4989	5018	5046	5074	5103	5131	5160	5188	5216	5245	5273	5301	5330	5358	5386	5415
12	5443	5471	5500	5528	5556	5585	5613	5642	5670	5698	5727	5755	5783	5812	5840	5868
13	5897	5925	5953	5982	6010	6038	6067	6095	6123	6152	6180	6208	6237	6265	6294	6322
14	6350	6379	6407	6435	6464	6492	6520	6549	6577	6605	6634	6662	6690	6719	6747	6775
15	6803	6832	6861	6889	6918	6946	6974	7002	7031	7059	7087	7116	7144	7172	7201	7229
16	7257	7286	7314	7343	7371	7399	7428	7456	7484	7513	7541	7569	7598	7626	7654	7683
17	7711	7739	7768	7796	7824	7853	7881	7909	7938	7966	7994	8023	8051	8080	8108	8136

INTERNATIONAL FERTILITY RESEARCH PROGRAM MULTIPLE BIRTH RECORD

Complete a separate form for each infant born in a multiple birth.

IDENTIFICATION OF MOTHER: 1 Hospital or clinic no. _____		2. Admission date _____ day month year
3 Mother's name _____		Father's name _____
4 Address _____		

STUDY IDENTIFICATION

- 5 Center name _____ and number

 1-3
- 6 Study number

 4-6
- 7 Maternity Record study number:

 7-9
- 8 Mother's patient order number on Maternity Record

 10-14
- 9 Delivery date

 day

 month

 year 15-20

MEDICAL DATA

- 10 Number of births this delivery

 21
- 11 Birth sequence of this infant: 1) first 2) second 3) third 4) fourth 5) fifth 6) sixth

 22
- 12 Presentation of this infant during labor: 0) vertex, occiput anterior 1) vertex, occiput transverse or posterior 2) frank breech 3) footling breech 4) complete breech 5) breech w/face 6) transverse lie 7) compound 8) other, specify _____

 23
- 13 Type of delivery this infant: 0) spontaneous 1) outlet forceps 2) vacuum extractor 3) mid- or high forceps 4) manual rotation 5) breech extraction 6) cesarean section 7) destructive procedure 8) other, specify _____

 24

- 14 Birth weight: (grams)

 15-28
- 15 Sex of this infant: 1) male 2) female 3) indeterminate

 29
- 16 Apgar score: 9) not done at 1 minute (8 or more = 8) at 5 minutes

 30

For Items 17-18, use the following codes (0 may be coded for both items. No other codes should be repeated):
0) normal, or stillbirth with no apparent pathology 1) fetal distress during labor 2) minor malformation 3) major malformation 4) respiratory distress syndrome 5) isoimmunization 6) neonatal sepsis 7) trauma 8) other

- 17 Primary fetal/neonatal condition (if coded 2, 3, 7 or 8, specify) _____

 32
- 18 Secondary fetal/neonatal condition (if coded 2, 3, 7 or 8, specify) _____

 33
- 19 Fetal/neonatal death: 0) none 1) antepartum 2) intrapartum 3) postpartum

 34

Recorder's name: _____

PLEASE AIRMAIL TO: International Fertility Research Program,
Research Triangle Park, North Carolina 27709 USA

INSTRUCTIONS FOR COMPLETING THE MULTIPLE BIRTH RECORD

The Multiple Birth Record should be completed whenever there is a multiple birth. Complete a separate Multiple Birth Record for each baby. Fill in only one Maternity Record Summary for the mother.

Identification of the Mother Items 1-4

- This information in the upper box is not mailed to the IFRP. The information should be the same as that on the mother's Maternity Record Summary.

Study Identification Items 5-9

5. Center name _____ and number: 1-3

- Write the name of the Center on the line. Fill in the unique three-digit number assigned to the Center in the three boxes on the right.

6. Study number 4-6

- The study number for the Multiple Birth Record will be assigned by the IFRP. All Multiple Birth Records will have the same study number, unless a special study is undertaken.

7. Maternity Record study number 7-9

- This is the same three-digit number found in Item 6 of the Maternity Record Summary.

8. Mother's patient order number on Maternity Record: 10-14

- This is the same five-digit number found in Item 7 on the Maternity Record Summary.

9. Delivery date: 15-20
day month year

- This is the same date found in Item 8 of the Maternity Record Summary.
- Note that Items 5-9 MUST MATCH EXACTLY the appropriate items on the Maternity Record Summary, or the computer will reject the entire form.

Medical Data Items 10-19

10. Number of births this delivery: 21

- Write in the box the number of infants delivered; write 2 if twins were born, 3 if triplets, etc.
- 0 or 1 should never be written in this box.

11. Birth sequence of this infant: 1) first 2) second 3) third 4) fourth 5) fifth 6) sixth 22

- Write in the box the order in which the infant was born in this delivery. If the infant was the second of triplets, write 2 in the box.
- Do not take into account the number of children the mother has borne before this delivery. Count only the present delivery.

12. Presentation of this infant during labor: 0) vertex, occiput anterior 1) vertex, occiput transverse or posterior 2) frank breech 3) footling breech 4) complete breech 5) brow/face 6) transverse lie 7, compound 8) other, specify _____ 23

- See Item 23 of the instructions for the Maternity Record Summary for definitions of the various presentations (especially breech presentations).
- The response to this item is not necessarily the same as the one to Item 23 of the Maternity Record Summary, since that refers only to the presentation of the infant who was the most difficult to deliver.

13. Type of delivery this infant: 0) spontaneous 1) outlet forceps 2) vacuum extractor 3) mid- or high forceps 4) manual rotation 5) breech extraction 6) cesarean section 7) destructive procedure 8) other, specify _____ 24

- See Item 24 of the instructions for the Maternity Record Summary for definitions of the methods of delivery.
- The response to this item is not necessarily the same as the one to Item 24 of the Maternity Record Summary, since that refers only to the method of delivery of the infant who was the most difficult to deliver.

EXAMPLE: The first twin is in vertex position and is satisfactorily delivered spontaneously. The second twin is in the breech position and is delivered by cesarean section. The correct coding is as follows:

Item	First twin	Second twin
10	2	2
11	1	2
12	0	2 (or 3 or 4)
13	0	6

14. Birth weight: (grams) 25-28

- Record birth weight in grams within one hour of delivery.
- Do not estimate weight.
- Do not include clothing, swaddling, etc.
- If the baby was not weighed, write 9999 in the boxes.
- The response to this item is not necessarily the same as the one to Item 27 on the Maternity Record Summary, since that refers only to the most difficult delivery.
- Record birth weight of this infant only, not total weight of all infants born this delivery.

15. Sex of this infant: 1) male 2) female 3) indeterminate 29

- If this infant is a male, write 1 in the box. Write 2 in the box if it is a female.
- If the sex of the baby cannot be determined (because of maceration or congenital ambiguity), write 3 in the box.

16. Apgar score: at 1 minute 30
9) not done (8 or more = 8)
at 5 minutes 31

- See Item 29 of the Maternity Record Summary for instructions on how to derive the Apgar score.
- Write the score for this baby at one minute and at five minutes in the appropriate box.

- If the baby dies before the evaluation is made, write **9** in the box.
- If the score is 8, 9 or 10, write **8** in the box.

• **For Items 17-18, use the following codes (0 may be coded for both items. No other codes should be repeated):** 0) normal, or still-birth with no apparent pathology 1) fetal distress during labor 2) minor malformation 3) major malformation 4) respiratory distress syndrome 5) isoimmunization 6) neonatal sepsis 7) trauma 8) other

17. Primary fetal/neonatal condition (if coded 2, 3, 7 or 8, specify): _____ 32

• For definition of the conditions, see instruction for Item 30 of the Maternity Record Summary.

• Record in this item the *primary* condition of this infant. If the infant has more than one condition, record the most severe (clinically most significant) in this item, and the less severe, or secondary condition, in item 18.

18. Secondary fetal/neonatal condition (if coded 2, 3, 7 or 8, specify): _____ 33

• Follow the directions for Item 17 above.

19. Fetal/neonatal death: 0) none 1) antepartum 2) intrapartum 3) postpartum 34

• The response to the item should be consistent with that of Item 31 on the Maternity Record Summary. This item refers to only one infant, however, and Item 31 on the Maternity Record Summary refers to all the infants born at this delivery.

• See the instructions for Item 31 of the Maternity Record Summary for definitions of the terms.

Recorder's name: _____

• The name of the person completing this form should be written **legibly** on the line.

• Attach the two or more completed Multiple Birth Records to the appropriate Maternity Record Summary, and mail them with the regular monthly shipment to the International Fertility Research Program.